STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E251	A. BUILDING _____ B. WING _____	C 01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENE MANOR MEDICAL CTR.	970 WRAY ST KNOXVILLE, TN 37917

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F 000	INITIAL COMMENTS Complaint investigations #TN00028916, #TN00028872, #TN00029002 and #TN00029000 were completed at Serene Manor Medical Center on January 5, 2012. No deficiencies were cited for complaints #TN00028872, #TN00029002 under 42CFR Part 483, Requirements for Long Term Care.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.		2-1972 **F 164 PRIVACY/CONFIDENTIALITY OF RECORDS** **Serene Manor residents will have the right to personal privacy and confidentiality of his or her personal and clinical records. 1. Corrective action has been accomplished for those residents found to have been affected by the following measures:** **a. Chart reviews of the residents affected have been conducted to verify the original medical records and photographs are still in the medical chart as according to Person # 1 telephone interview with a Health Care Facility representative noted In the 2567 illegally copied medical records without a release signed by two residents, took an unauthorized photograph of one resident, copied photographs unauthorized of three residents and was in possession of medical records of six residents totaling "about a thousand pages".**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rita Griffin | Administrator | 1-20-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 164	Continued From page 1	F 164		

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to provide personal privacy for three residents (#6, #7, #8) and maintain confidentiality of medical records for six residents (#5, #8, #9, #13, #14, #15) of sixteen sampled residents.

The findings included:

Telephone interview with Person #1 on December 12, 2011, at 11:47 a.m., revealed Person #1 took an unauthorized photograph of sampled Resident #6 and was in unauthorized possession of photographs of sampled Residents #6, #7 and #8. Continued interview revealed Person #1 photocopied a Medication Administration Record (MAR) of Resident #9 and Person #1 stated, " ...(Resident #9's MAR) right here in my paper work ..." Continued interview revealed Person #1 was in possession of the following medical records:

Resident #5: physician progress notes
Resident #8: physician orders and nurse's notes
Resident #9: Medication Administration Record
Resident #13: nurse's notes
Resident #14: weight record
Resident #15: physician orders and nurse's notes

Continued interview revealed Person #1's intent to transmit the photographs and one page of medical records via electronic mail for each resident for which Person #1 had medical

b. Staff education was conducted January 18, 2012 by Facility Consultant and Administrator verifying all staff know who is authorized to access and review medical records of residents according to facility policy. Education included record release is required by law from the resident except when required by transfer to another healthcare institution; law or third party payment contract to copy or release personal and clinical records to any individual outside the facility. Education included HIPPA Regulations regarding personal privacy of medical treatment, written and telephone communications, personal care, visits, and meetings of family. Education included who is authorized to copy medical records with a signed release from the resident. Education included the authorized persons who have a key to the chart rack which is to remain locked at all times unless under direct supervision and use of an authorized individual. Medical Records are to never be left unattended by an authorized person in any location. Staff education also included expected, necessary, and required integrity of each staff member for continued employment at this facility.

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F 164	Continued From page 2 records, and Person #1 stated, " ...I have about a thousand pages ..." Review of electronic mail from Person #1 dated December 12, 2011, revealed a physician order (Resident #9) and included, "5-23-11 C + S (culture and sensitivity) of R (right) arm wound ..." Review of electronic mail from Person #1 dated December 12, 2011, revealed, "Nursing Alert 72 Hour Charting (Resident #13) ...6/19/10 ..." Telephone interview with Person #1 on December 13, 2011, at approximately 1:00 p.m., revealed Person #1 had sent photographs and/or medical records for eight residents via e-mail on December 12, 2011, and six of the eight documents had not been received. Medical record review for Sampled Residents #5-9, and #13-15 on December 12, 2011, and January 4-5, 2012, revealed Person #1 was not a responsible party or contact person for either of the eight residents and was not authorized to take photo's/copies of the residents. Medical record review (Resident #9) of a physician's order dated May 23, 2011, revealed, "C + S of R arm wound..." Medical record review (Resident #13) revealed no documentation regarding "Nursing Alert 72 Hour Charting ...6/19/10 ..." Interview with the Administrator on January 5, 2012, at 4:30 p.m., in her office, revealed the facility had not received authorization to release photographs and/or medical records to Person	F 164	**c. Chart Racks were modified for better security in the locking process with keys individually provided to only authorized staff with the nurse ultimately in charge of accessing the medical records for outside authorized persons via third party payment and securing the medical record upon returning to the chart rack. Security checks performed and documented three times per day in place already will have the additional procedure of verifying chart racks are locked.** **d. Cell phone policy of Serene Manor has been updated to restrict the use of a cell phone except in designated areas break and lunch times only away from resident areas.** 2. Facility will identify other residents having the potential to affected by the same practice and corrective action taken with chart audits to verify the original medical records and photographs are still in the medical chart and legal counsel has been consulted regarding violation of HIPPA Law committed against our residents and the facility to regain confidentiality of all residents' personal and medcal records with authorization granted to move forward in this matter. The use of cell phones have been restricted except in designated	

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areas at break and lunch times only.
Staff education was conducted January 18, 2011 regarding HIPPA law Regulations and Serene Manor policy by facility Consultant and Administrator.

3. Measures put into place or systemic changes made to ensure the Deficient practice does not recur is:
Chart Racks were modified for better security in the locking process with keys individually provided to only authorized staff with the nurse ultimately in charge of accessing the medical records for outside authorized persons via third party payment and securing the medical record upon returning to the chart rack. Chart racks are required to remain locked at all times unless under direct supervision of an authorized person.
Cell phone policy of Serene Manor has been updated to prohibit the use of a cell phone except in designated areas at break and lunch times only away from resident areas.
Security checks performed and documented three times per day in place already will have the additional procedure of verifying chart racks are locked.

4. Corrective actions will be monitored to ensure the deficient practice will not recur with the Quality Assurance Nurse continued staff education. The Quality Assurance nurse and Director of Nursing will monitor on a weekly basis staff knowledge regarding medical record security and privacy with one on one interviews. Nurse Supervisors will daily monitor and report to Director of Nursing facility policy compliance regarding cell phones and medical record compliance. Administrator and Director of Nursing will discuss at the next Quality Assurance Meeting results of medical record privacy compliance and cell phone policy.

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F 164	Continued From page 3 #1. Continued interview confirmed the facility failed to provide personal privacy for Residents #6, #7, and #8 (photos taken without authorization), and confidentiality of medical records for Residents #5 - #9 and Residents #13 - #15.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	**F225 INVESTIGATION/REPORT ALLEGATIONS/INDIVIDUALS** **1. The facility will have evidence that all incidents are thoroughly investigated. Director of Nursing interviewed CNA# 4 with documentation this CNA had no Information regarding the incident. CNA #4 had told CNA# 2 that Resident #6 was trying to get up from bed as CNA# 2 was approaching resident's room. Director of Nursing interviewed RN# 1 with documentation this RN was paged to the dining room where Resident# 6 was in a geri-chair upon his arrival and he provided no assistance as LPN# 2 told him she did not need his assistance the situation was under control. An in-service was conducted on January 18th 2012 to educate staff that any person who has knowledge of the resident surrounding the incident time will be requested to be interviewed with documentation or provide documentation. In-service was conducted by Facility Advisor and Administrator.**	1-20-12

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F 225	Continued From page 4 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, and interview, the facility failed to thoroughly investigate an injury of unknown origin for one resident (#6) of sixteen sampled residents. The findings included: Resident #6 was admitted to the facility on April 11, 2011, with diagnoses including Alzheimer's Disease, Acute Renal Failure, Chronic Obstructive Pulmonary Disease, and Anemia. Medical record review of the MDS dated October 27, 2011, revealed the resident was impaired with decision-making skills, had no behavioral problems or history of falls, and was non-ambulatory and totally dependent on staff for transfers and mobility. Continued review revealed the resident weighed seventy-nine pounds and was free of skin impairment. Medical record review of a nurse's note dated November 5, 2011, at 11:30 p.m., revealed, "Resident sitting in dining room in Geri chair with foot rest elevated. it was noted a 6 inches long deep laceration to outer calf left leg. No bleeding	F 225	**2. This facility will identy other residents having the potential to be affected by the same deficient practice with corrective action taken: Incident investigations were reviewed to verify there were witnesses with no documentation completed. An in-service was conducted on January 18, 2012 to educate staff that any person who has knowledge of the resident surrounding the incident time will be requested to be interviewed and documented or provide documentation which will include date and time.** **3. Systematic changes made to ensure the deficient practice does not recur are: An RN was hired full time as Quality Assurance Nurse who has experience and extra training by Facility Advisor on Incident Investigations and an in-service was conducted on January 18, 2012 to educate staff that any person who has knowledge of the resident surrounding the incident time will be requested to be interviewed and documented or provide documentation which will include date and time.**	

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F 225	Continued From page 5 noted...no c/o pain or other discomforts from site moves toes freely. pedal and tibial pulse present. moist 4 x 4 applied...and wrapped.. Resident aware of laceration when wet from 4 x 4 on back of leg felt. Hematoma formed and bleeding." Medical record review revealed the physician was notified and the resident was transported to the hospital on November 6, 2011, at 12:10 a.m. Medical record review of an Emergency Provider Record dated November 6, 2011, at 1:10 a.m., revealed, "...found in chair with lac (laceration) per nsg (nursing) staff ? if caught in chair when reclined staff unsure of mechanism of injury...deep tissue lac...length 17 cm (centimeters) left lat (lateral) lower leg..." Medical record review of a nurse's note dated November 6, 2011, at 3:15 a.m., revealed the resident returned to the facility. Medical record review of a physician's order dated November 7, 2011, revealed, "...adm (admit) to (hospital) for wound debridement." Medical record review of a discharge summary dated November 9, 2011, revealed, "...skin very fragile...After suffering a severe skin tear on...leg when (resident) accidentally dropped it through a gerichair. Transferred to (hospital)..." Medical record review revealed the resident did not return to the facility. Review of facility investigation documentation dated November 5, 2011, revealed, "...Time of incident: 11:30 p.m...CNA (certified nursing assistant) assigned to resident : (CNA #3)...Nurse on duty: (RN - Registered Nurse #1), (LPN-Licensed Practical Nurse #2)...deep laceration..."	F 225	**4. Monitoring to ensure the deficient practice will not recur will be completed on a weekly basis by Facility Advisor and Administrator. Director of Nursing or Quality Assurance RN will daily monitor and verify documentation of witness statements and complete investigation documentation. Incident Investigations will be discussed at the next regularly scheduled Quality Assurance Meeting to verify continued compliance.**	

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F 225	Continued From page 6 Continued review revealed, "...Measures taken to prevent recurrence of this type event:..." was blank. Review of facility investigation documentation dated November 5, 2011, at 11:51 p.m., (statement of CNA #1) revealed, "...on or about 11:00 p.m., I noticed (CNA #2) was bringing (resident) to the first floor day room in a geri-chair with (resident's) feet already elevated. (CNA #2) then clocked out and left...After a few minutes had went by I noticed (CNA #3) wanting to assure that (resident) was warm and wanted to cover (resident) up. So she got a sheet. I then stepped out on porch and upon entering the doors I heard (CNA #3) say 'Who's the nurse...(CNA #3) then went to the phone and paged (RN #1) to first floor stat. At that time I noticed that (resident) had a laceration on (resident's) lower left leg. At the first sight of it, it appeared to be deep...also noticed that (resident) had on two long (tube socks)...left sock was up over the laceration..." Review of facility investigation documentation dated November 5, 2011, revealed, "...(resident) sleeping good at 10:50 (p.m.)...(CNA #4) told me (CNA #2) that (resident) was trying to get up from bed, I got up to get geri-chair to put (resident) in, put pad in chair, put blanket around (resident), put (resident) in chair put on socks, put sheet on (resident), took...to day room, sat (resident) by me and (LPN #1) told night CNA please put (resident) to bed before 5:30 a.m. clocked out and left." Review of facility investigation documentation dated November 6, 2011, revealed, "When I (CNA #3) arrived (resident) was being rolled	F 225		

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F 225	Continued From page 7 down the hall in a Geri chair with the foot rest up by (CNA #2) and taken into day room...I went to get a sheet to cover (resident) up when I started to cover (resident) I noticed (resident's) leg hanging between the seat and arm rest. (Resident) had on...socks. I lifted (resident's) leg up and saw...leg was bleeding, so I called the nurse." Review of facility investigation documentation revealed no witness statements from RN #1 or CNA #4. Observation of the geri-chair with LPN #2 on January 5, 2012, revealed a space of approximately one inch between the seat and the side of the chair and a covered screw projected out in the space between the seat and the left side of the chair. Interview with RN #1 on January 5, 2012, at 3:47 p.m., in the administrator's office, revealed the RN had not observed the resident attempt to get out of the geri-chair unassisted. Interview with the Director of Nursing on January 5, 2012, at 3:50 p.m., in the administrator's office, revealed the facility had no additional investigation documentation, and confirmed the facility had failed to thoroughly investigate the resident's injury. C/O: #28916, #29000	F 225		1-20-12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	**F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** **1. This facility will provide separately locked permanently affixed compartment for storage of controlled drugs and other drugs subject to abuse in the medication cart with corrective action accomplished was one-on-one education with RN#1 who had entered a resident room out of line of sight of the cart with open door and the storage box for narcotics was under a single lock on December 12, 2011 immediately. RN#1 has assured facility Administrator he will be diligent in remembering to lock the medication cart when the cart is out of line of view and was**	

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F 431	Continued From page 8 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain narcotic medications under double-lock for one medication cart on one floor (third) of three floors.	F 431	reminded in additional education on January 18, 2012 with all licensed personnel. 2. Facility will identify other residents having the Potential to be affected by the same deficient Practice with corrective action taken: on December 12, 2011 RN#1 assured facility Administrator and Director of Nursing he will be diligent in remembering to lock the medication cart when the cart is out of line of view and was reminded in additional education on January 18, 2012 with all licensed personnel education. 3. Systematic changes made to ensure the deficient practice does not recur is licensed personnel was educated on January 18, 2012 by Facility Advisor and Administrator on diligence regarding medication carts locked when out of sight. Security checks performed and documented three times per day already in place will have the additional procedure of verifying medication carts are locked when out of sight of nurse on duty. These security checks will be three times a day reminder also to the nurse on duty the importance of locking the medication carts.	

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F 431	Continued From page 9 The findings included: Observation on December 12, 2011, at 4:32 p.m., revealed a medication cart in the hallway of the third floor, the medication cart door was open and the storage box for narcotics was under a single lock. Continued observation revealed the nurse was inside a resident's room and out of line of sight of the cart. Interview with the Registered Nurse (RN #1) on December 12, 2011, at approximately 4:34 p.m., in the third floor hallway, revealed RN #1 was unable to see the cart from his location in the patient's room. Continued interview confirmed the facility had failed to maintain narcotic medications under a double-lock.	F 431	**4. Corrective acton will be monitored to ensure practice will not recur by House Supervisor, Director of Nursing or, Quality Assurance RN observing medication pass. All staff will assist in this monitoring on a daily basis when walking by a medication cart to verify doors are closed if the medication cart is in the hallway and the nurse is not present immediately alerting the nurse administering medications. This monitoring will be discussed at the next scheduled Quality Assurance Meeting for confirmation of continued compliance.**	

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